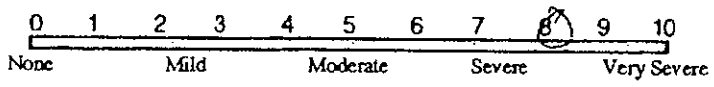
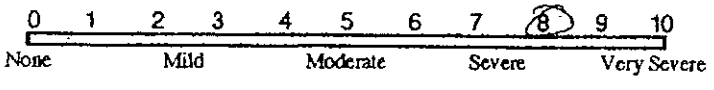
5. Symptom Severity: For each of the following symptoms please mark the scale that most closely correlates with the degree of the symptom over the past week.

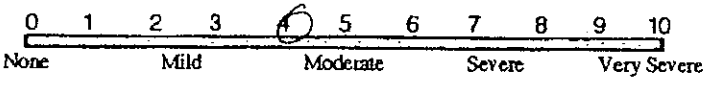
Fatigue or exhaustion:



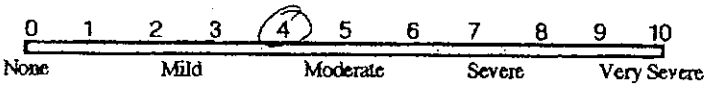
Impaired memory or concentration



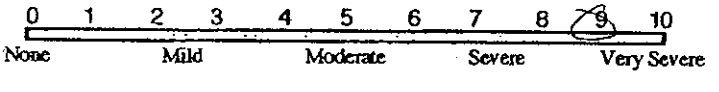
Sore throat:



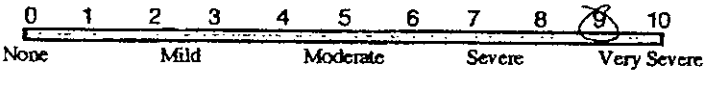
Tender lymph nodes:



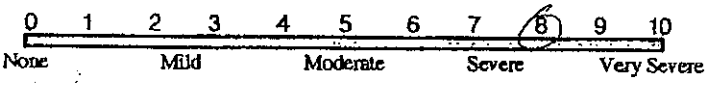
Muscle pain:



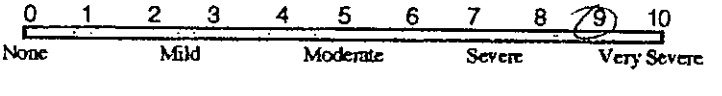
Joint pain:



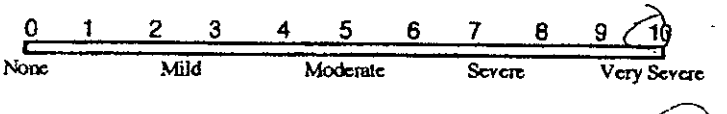
Headache:



Unrefreshing sleep:



Malaise or exhaustion after exertion:



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7. Activity Estimate: Please estimate your overall activity in the past month as to what your activity would be if you were well.

Please circle one: (10%) 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Wood Mental Fatigue Inventory (*Br J Clin Psych* 1993; 32:375-9.) In the past week, how much have you been bothered by each of the following? Please circle the appropriate number.

	Not at all	A little	Somewhat	Quite a lot	Very much
1. Spells of confusion	0	1	2	(3)	4
2. Thoughts getting mixed up	0	1	2	(3)	4
3. Poor concentration	0	1	2	(3)	4
4. Can't easily make decisions	0	1	2	(3)	4
5. Poor memory for recent events	0	1	2	3	(4)
6. Can't take things in when speaking to people	0	1	2	(3)	4
7. Thoughts are slow	0	1	2	(3)	4
8. Muzzy or foggy head	0	1	2	(3)	4
9. Can't find the right words	0	1	2	(3)	4

9. Epworth Sleepiness Scale: (Johns MW. *Sleep* 1991;14:540-545) Over the past few weeks, how likely are you to doze or fall asleep in trhe following situations, in contrast to feeling just tired?

Situation	would never doze	slight chance of dozing	moderate chance	high chance
Sitting and reading	(0)	1	2	3
Watching TV	(0)	1	2	3
Sitting (inactive) in public	(0)	1	2	3
As a passenger in a car for one hour without a break	(0)	1	2	3
Lying down to rest in the afternoon	(0)	1	2	3
Sitting and talking to someone	(0)	1	2	3
Sitting quietly after lunch without alcohol	(0)	1	2	3
In a car, while stopped for a few minutes in traffic	(0)	1	2	3

6. Fatigue Impact Scale. [Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.] The following statements are designed to determine how much impact fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact, 1 for slight impact, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	2	3	4
2. I am more isolated from social contact.	0	1	2	3	4
3. I have to reduce my workload or responsibilities.	0	1	2	3	4
4. I am more moody.	0	1	2	3	4
5. I have difficulty paying attention for a long period.	0	1	2	3	4
6. I feel like I cannot think clearly.	0	1	2	3	4
7. I work less effectively (work inside or outside the home).	0	1	2	3	4
8. I have to rely more on others to help me or do things for me.	0	1	2	3	4
9. I have difficulties planning activities ahead of time.	0	1	2	3	4
10. I am more clumsy and uncoordinated.	0	1	2	3	4
11. I find that I am more forgetful.	0	1	2	3	4
12. I am more irritable and more easily angered.	0	1	2	3	4
13. I have to be careful about pacing my physical activities.	0	1	2	3	4
14. I am less motivated to do anything that requires physical effort.	0	1	2	3	4
15. I am less motivated to engage in social activities.	0	1	2	3	4
16. My ability to travel outside my home is limited.	0	1	2	3	4
17. I have trouble maintaining physical effort for long periods	0	1	2	3	4
18. I find it difficult to make decisions.	0	1	2	3	4
19. I have few social contacts outside of my own home.	0	1	2	3	4
20. Normal day-to-day events are stressful for me.	0	1	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	2	3	4
22. I avoid situations that are stressful for me.	0	1	2	3	4
23. My muscles feel much weaker than they should.	0	1	2	3	4
24. My physical discomfort is increased.	0	1	2	3	4
25. I have difficulty dealing with anything new.	0	1	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	2	3	4
27. I feel unable to meet the demands that people place on me.	0	1	2	3	4
28. I am less able to provide financial support for myself and my family.	0	1	2	3	4
29. I engage in less sexual activity.	0	1	2	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	3	4
31. I am less able to complete tasks that require physical effort.	0	1	2	3	4
32. I worry about how I look to other people.	0	1	2	3	4
33. I am less able to deal with emotional issues.	0	1	2	3	4
34. I feel slowed down in my thinking.	0	1	2	3	4
35. I find it hard to concentrate.	0	1	2	3	4
36. I have difficulty participating fully in family activities.	0	1	2	3	4
37. I have to limit my physical activities.	0	1	2	3	4
38. I require more frequent and longer periods of rest.	0	1	2	3	4
39. I am not able to provide as much emotional support to my family.	0	1	2	3	4
40. Minor difficulties seem like major difficulties.	0	1	2	3	4

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040907018478 77 SOUTH MAIN STREET
LYNDONVILLE, NEW YORK 14098

Chronic Fatigue Syndrome Follow-up Form

Name Ann Magee Date: 10/24/03

1. Global Impression of Severity: Please check the level which most applies to you in the past 2 weeks.

____ 1. I feel well and vigorous, and have normal daily activity.
____ 2. I feel mildly ill, and have some restriction of activity due to fatigue.
____ 3. I feel moderately ill, and my activity is restricted on a daily basis.
____ 4. I feel quite ill much of the time, and my activity is quite restricted.
X 5. I feel very ill, and my activity is severely restricted.
____ 6. I feel extremely ill, and rarely get out of bed.

2. Please list all medications you are taking:

1. Effexor XR 225mg/day
2. Lipitor 40mg/day
3. Klonopin PRN
4. Cosopt 2 drops/day/eye
5.
6.
7.
8.
9.
10.

3. Since your last visit here, have you been diagnosed with any other illnesses? NO
If yes, please describe:

4. Daily Activity: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

a) Total hours sleeping: 8

b) Rest, but not sleeping:
(resting, watching TV, light reading, etc) 10

c) Light to moderate activity:
(shopping, housework, meals, etc): 6

d) Vigorous activity
(exercise, heavy cleaning, sports, etc): 0
24 hours

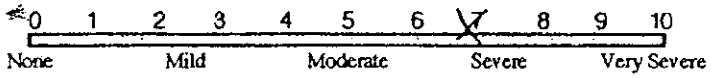
(6)

e) How many hours could you be out of the house at any one time on average during the past 2 weeks?

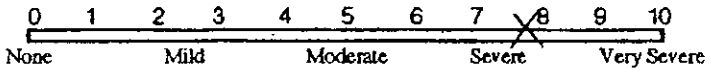
8 hours

5. Symptom Severity: For each of the following symptoms please mark the scale that most closely correlates with the degree of the symptom over the past week.

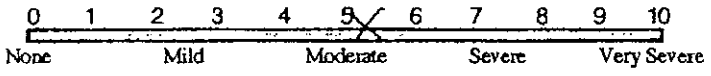
Fatigue or exhaustion:



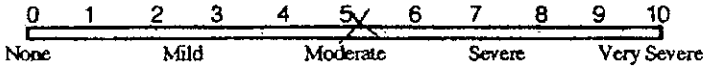
Impaired memory or concentration



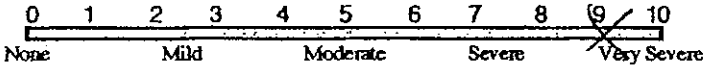
Sore throat:



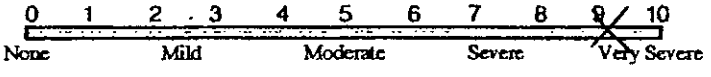
Tender lymph nodes:



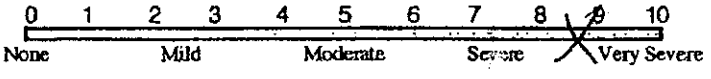
Muscle pain:



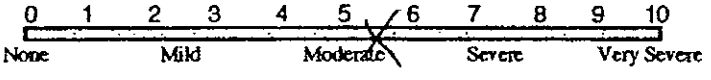
Joint pain:



Headache:



Unrefreshing sleep:



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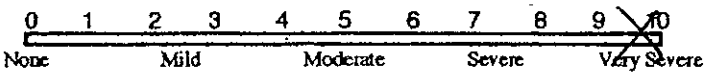

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7. Activity Estimate: Please estimate your overall activity in the past month as to what your activity would be if you were well.

Please circle one: 10% 20% (30%) 40% 50% 60% 70% 80% 90% 100%

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4. Can't easily make decisions	0	1	(2)	3	4
5. Poor memory for recent events	0	1	2	(3)	4
6. Can't take things in when speaking to people	0	1	2	3	(4)
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8. Muzzy or foggy head	0	1	2	(3)	4
9. Can't find the right words	0	1	2	(3)	4

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Watching TV	0	1	(2)	3
Sitting (inactive) in public	(0)	1	2	3
As a passenger in a car for one hour without a break	(0)	1	2	3
Lying down to rest in the afternoon	(0)	1	2	3
Sitting and talking to someone	(0)	1	2	3
Sitting quietly after lunch without alcohol	(0)	1	2	3
In a car, while stopped for a few minutes in traffic	(0)	1	2	3

6. Fatigue Impact Scale. [Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.] The following statements are designed to determine how much impact fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact, 1 for slight impact, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

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2. I am more isolated from social contact.	0	1	2	3	4
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4. I am more moody.	0	1	2	3	4
5. I have difficulty paying attention for a long period.	0	1	2	3	4
6. I feel like I cannot think clearly.	0	1	2	3	4
7. I work less effectively (work inside or outside the home).	0	1	2	3	4
8. I have to rely more on others to help me or do things for me.	0	1	2	3	4
9. I have difficulties planning activities ahead of time.	0	1	2	3	4
10. I am more clumsy and uncoordinated.	0	1	2	3	4
11. I find that I am more forgetful.	0	1	2	3	4
12. I am more irritable and more easily angered.	0	1	2	3	4
13. I have to be careful about pacing my physical activities.	0	1	2	3	4
14. I am less motivated to do anything that requires physical effort.	0	1	2	3	4
15. I am less motivated to engage in social activities.	0	1	2	3	4
16. My ability to travel outside my home is limited.	0	1	2	3	4
17. I have trouble maintaining physical effort for long periods	0	1	2	3	4
18. I find it difficult to make decisions.	0	1	2	3	4
19. I have few social contacts outside of my own home.	0	1	2	3	4
20. Normal day-to-day events are stressful for me.	0	1	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	2	3	4
22. I avoid situations that are stressful for me.	0	1	2	3	4
23. My muscles feel much weaker than they should.	0	1	2	3	4
24. My physical discomfort is increased.	0	1	2	3	4
25. I have difficulty dealing with anything new.	0	1	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	2	3	4
27. I feel unable to meet the demands that people place on me.	0	1	2	3	4
28. I am less able to provide financial support for myself and my family.	0	1	2	3	4
29. I engage in less sexual activity.	0	1	2	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	3	4
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33. I am less able to deal with emotional issues.	0	1	2	3	4
34. I feel slowed down in my thinking.	0	1	2	3	4
35. I find it hard to concentrate.	0	1	2	3	4
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37. I have to limit my physical activities.	0	1	2	3	4
38. I require more frequent and longer periods of rest.	0	1	2	3	4
39. I am not able to provide as much emotional support to my family.	0	1	2	3	4
40. Minor difficulties seem like major difficulties.	0	1	2	3	4

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DAVID S. BELL, M.D.
77 SOUTH MAIN STREET
LYNDONVILLE, NEW YORK 14098

Chronic Fatigue Syndrome Follow-up Form

Name Lisa Magee Date: 8/11

1. Global Impression of Severity: Please check the level which most applies to you in the past 2 weeks.

____ 1. I feel well and vigorous, and have normal daily activity.
____ 2. I feel mildly ill, and have some restriction of activity due to fatigue.
____ 3. I feel moderately ill, and my activity is restricted on a daily basis.
X 4. I feel quite ill much of the time, and my activity is quite restricted.
____ 5. I feel very ill, and my activity is severely restricted.
____ 6. I feel extremely ill, and rarely get out of bed.

2. Please list all medications you are taking:

1. effexor XR 225 mg. qd
2. celebrex 200 mg. qd
3. lipitor 40 mg qd
4. ridium 20 mg. 100's
5.
6.
7.
8.
9.
10.

3. Since your last visit here, have you been diagnosed with any other illnesses?
If yes, please describe:
no

4. Daily Activity: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

a) Total hours sleeping: 10

b) Rest, but not sleeping:
(resting, watching TV, light reading, etc) 11

c) Light to moderate activity:
(shopping, housework, meals, etc): 3

d) Vigorous activity
(exercise, heavy cleaning, sports, etc): 0
24 hours

(3)

e) How many hours could you be out of the house at any one time on average during the past 2 weeks?

2 hours

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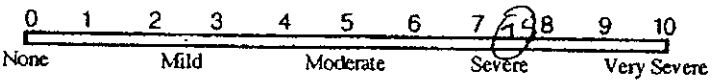
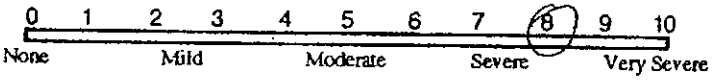
5. Symptom Severity: For each of the following symptoms please mark the scale that most closely correlates with the degree of the symptom over the past week.

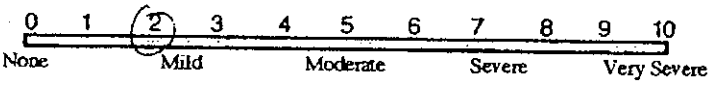
Fatigue or exhaustion:



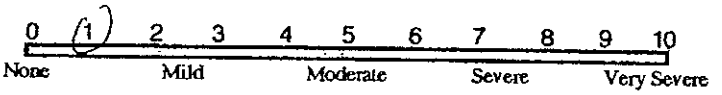
Impaired memory or concentration



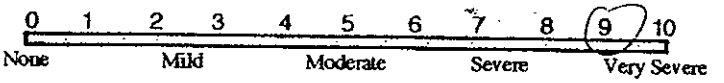
Sore throat:



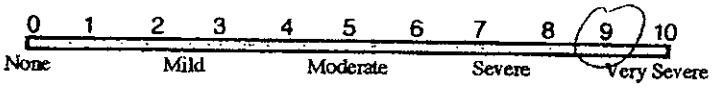
Tender lymph nodes:



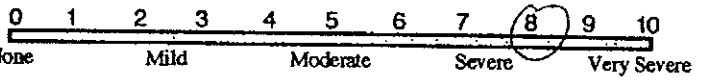
Muscle pain:



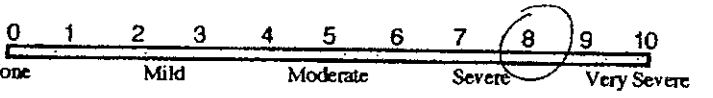
Joint pain:



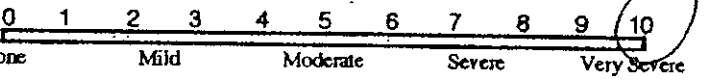
Headache:



Unrefreshing sleep:



Malaise or exhaustion after exertion:



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7. Activity Estimate: Please estimate your overall activity in the past month as to what your activity would be if you were well.

Please circle one: (10%) 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Wood Mental Fatigue Inventory (*Br J Clin Psych* 1993; 32:375-9.) In the past week, how much have you been bothered by each of the following? Please circle the appropriate number.

	Not at all	A little	Somewhat	Quite a lot	Very much
1. Spells of confusion	0	1	(2)	3	4
2. Thoughts getting mixed up	0	1	(2)	3	4
3. Poor concentration	0	1	(2)	3	4
4. Can't easily make decisions	(0)	1	2	3	4
5. Poor memory for recent events	0	1	2	3	(4)
6. Can't take things in when speaking to people	0	1	2	(3)	4
7. Thoughts are slow	0	1	2	(3)	4
8. Muzzy or foggy head	0	1	2	(3)	4
9. Can't find the right words	0	1	2	3	(4)

9. Epworth Sleepiness Scale: (Johns MW. *Sleep* 1991;14:540-545) Over the past few weeks, how likely are you to doze or fall asleep in trhe following situations, in contrast to feeling just tired?

Situation	would never doze	slight chance of dozing	moderate chance	high chance
Sitting and reading	(0)	1	2	3
Watching TV	(0)	1	2	3
Sitting (inactive) in public	(0)	1	2	3
As a passenger in a car for one hour without a break	(0)	1	2	3
Lying down to rest in the afternoon	0	(1)	2	3
Sitting and talking to someone	(0)	1	2	3
Sitting quietly after lunch without alcohol	(0)	1	2	3
In a car, while stopped for a few minutes in traffic	(0)	1	2	3

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6. Fatigue Impact Scale. [Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.] The following statements are designed to determine how much impact fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact, 1 for slight impact, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	2	3	4
2. I am more isolated from social contact.	0	1	2	3	4
3. I have to reduce my workload or responsibilities.	0	1	2	3	4
4. I am more moody.	0	1	2	3	4
5. I have difficulty paying attention for a long period.	0	1	2	3	4
6. I feel like I cannot think clearly.	0	1	2	3	4
7. I work less effectively (work inside or outside the home).	0	1	2	3	4
8. I have to rely more on others to help me or do things for me.	0	1	2	3	4
9. I have difficulties planning activities ahead of time.	0	1	2	3	4
10. I am more clumsy and uncoordinated.	0	1	2	3	4
11. I find that I am more forgetful.	0	1	2	3	4
12. I am more irritable and more easily angered.	0	1	2	3	4
13. I have to be careful about pacing my physical activities.	0	1	2	3	4
14. I am less motivated to do anything that requires physical effort.	0	1	2	3	4
15. I am less motivated to engage in social activities.	0	1	2	3	4
16. My ability to travel outside my home is limited.	0	1	2	3	4
17. I have trouble maintaining physical effort for long periods	0	1	2	3	4
18. I find it difficult to make decisions.	0	1	2	3	4
19. I have few social contacts outside of my own home.	0	1	2	3	4
20. Normal day-to-day events are stressful for me.	0	1	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	2	3	4
22. I avoid situations that are stressful for me.	0	1	2	3	4
23. My muscles feel much weaker than they should.	0	1	2	3	4
24. My physical discomfort is increased.	0	1	2	3	4
25. I have difficulty dealing with anything new.	0	1	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	2	3	4
27. I feel unable to meet the demands that people place on me.	0	1	2	3	4
28. I am less able to provide financial support for myself and my family.	0	1	2	3	4
29. I engage in less sexual activity.	0	1	2	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	3	4
31. I am less able to complete tasks that require physical effort.	0	1	2	3	4
32. I worry about how I look to other people.	0	1	2	3	4
33. I am less able to deal with emotional issues.	0	1	2	3	4
34. I feel slowed down in my thinking.	0	1	2	3	4
35. I find it hard to concentrate.	0	1	2	3	4
36. I have difficulty participating fully in family activities.	0	1	2	3	4
37. I have to limit my physical activities.	0	1	2	3	4
38. I require more frequent and longer periods of rest.	0	1	2	3	4
39. I am not able to provide as much emotional support to my family.	0	1	2	3	4
40. Minor difficulties seem like major difficulties.	0	1	2	3	4

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Painful Sensory Neuropathy

Mendell JR, Sobert Z.

NEJM 2003; 345:13:1243-55

celebrex 200/d

			Notes
Tricyclics			
	Nortriptylline (Pamelor)	75-150 mg/day start 10 mg/day	began 25 6 PM then 50 6 PM increase to 50 bid 25 in AM (5/22/03)
SSRIs			
	Paroxetine (Paxil)	20-60 mg/day	Antagonizes narcotics Potentiates bupropion
Other			
	Venlafaxine	150-375 mg/day start 37.5mg/day	on 150 qd (5/1/03)
	Bupropion	200-400 mg/day start 100 mg/day	on 200 qd (5/1/03)
Anticonvulsants			
	Carbamazepine (Tegretol)	1000-1600/day start 200 mg/day	Potentiates CNS depression
	Gabopentin (Neurontin)	1800-3600mg/day start 300 mgTID	tried 900 mg recently no response
	Clonazepan (Klonopin)	5-20mg/day start 0.5 mg/day	
	Toperamate (Topamax)	400-800 mg/day start 25 mg/day	

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DAVID S. BELL, M.D.
77 SOUTH MAIN STREET
LYNDONVILLE, NEW YORK 14098

Chronic Fatigue Syndrome Follow-up Form

Name John Magee **Date:** 5/1/03

1. Global Impression of Severity: Please check the level which most applies to you in the past 2 weeks.

___ 1. I feel well and vigorous, and have normal daily activity.
___ 2. I feel mildly ill, and have some restriction of activity due to fatigue.
___ 3. I feel moderately ill, and my activity is restricted on a daily basis.
___ 4. I feel quite ill much of the time, and my activity is quite restricted.
X 5. I feel very ill, and my activity is severely restricted.
___ 6. I feel extremely ill, and rarely get out of bed.

2. Please list all medications you are taking:

1. Celebrex 200mg/day
2. Wellbutrin 200mg/day
3. Effexor XR 150mg/day
4. Lipitor 20mg/day
5. B-12 500ug/day
6. Cosopt 1 drop/eye/ax day
7.
8.
9.
10.

3. Since your last visit here, have you been diagnosed with any other illnesses?
If yes, please describe: High cholesterol

4. Daily Activity: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

a) Total hours sleeping: 4

b) Rest, but not sleeping:
(resting, watching TV, light reading, etc) 16

c) Light to moderate activity:
(shopping, housework, meals, etc): 3.5

d) Vigorous activity
(exercise, heavy cleaning, sports, etc): .5

24 hours

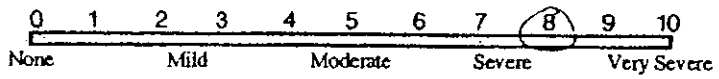
4

e) How many hours could you be out of the house at any one time on average during the past 2 weeks?

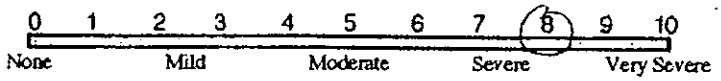
3 hours

5. Symptom Severity: For each of the following symptoms please mark the scale that most closely correlates with the degree of the symptom over the past week.

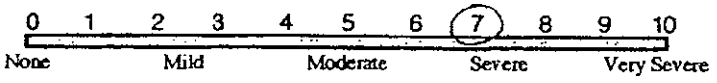
Fatigue or exhaustion: /



Impaired memory or concentration

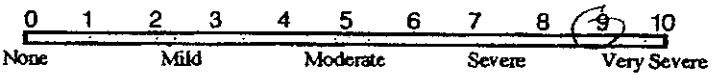


Sore throat: /

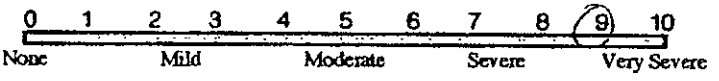


Tender lymph nodes:

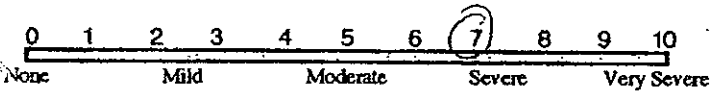
Muscle pain:



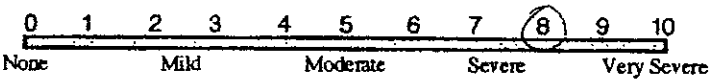
Joint pain:



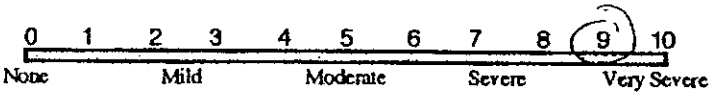
Headache: ✓



Unrefreshing sleep:



Malaise or exhaustion after exertion:



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7. Activity Estimate: Please estimate your overall activity in the past month as to what your activity would be if you were well.

Please circle one: (10%) 20% 30% 40% 50% 60% 70% 80% 90% 100%

8. Wood Mental Fatigue Inventory (*Br J Clin Psych* 1993; 32:375-9.) In the past week, how much have you been bothered by each of the following? Please circle the appropriate number.

	Not at all	A little	Somewhat	Quite a lot	Very much
1. Spells of confusion	0	1	(2)	3	4
2. Thoughts getting mixed up	0	1	(2)	3	4
3. Poor concentration	0	1	2	(3)	4
4. Can't easily make decisions	0	1	2	(3)	4
5. Poor memory for recent events	0	1	2	3	(4)
6. Can't take things in when speaking to people	0	1	(2)	3	4
7. Thoughts are slow	0	1	(2)	3	4
8. Muzzy or foggy head	0	1	2	(3)	4
9. Can't find the right words	0	1	2	(3)	4

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Situation	would never doze	slight chance of dozing	moderate chance	high chance
Sitting and reading	(0)	1	2	3
Watching TV	(0)	1	2	3
Sitting (inactive) in public	(0)	1	2	3
As a passenger in a car for one hour without a break	(0)	1	2	3
Lying down to rest in the afternoon	0	(1)	2	3
Sitting and talking to someone	(0)	1	2	3
Sitting quietly after lunch without alcohol	(0)	1	2	3
In a car, while stopped for a few minutes in traffic	(0)	1	2	3

6. Fatigue Impact Scale. {Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.} The following statements are designed to determine how much impact fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact, 1 for slight impact, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	(2)	3	4
2. I am more isolated from social contact.	0	1	2	(3)	4
3. I have to reduce my workload or responsibilities.	0	1	2	3	(4)
4. I am more moody.	0	1	2	(3)	4
5. I have difficulty paying attention for a long period.	0	1	2	(3)	4
6. I feel like I cannot think clearly.	0	1	(2)	3	4
7. I work less effectively (work inside or outside the home).	0	1	2	3	(4)
8. I have to rely more on others to help me or do things for me.	0	1	2	(3)	4
9. I have difficulties planning activities ahead of time.	0	1	2	(3)	4
10. I am more clumsy and uncoordinated.	0	1	(2)	3	4
11. I find that I am more forgetful.	0	1	2	(3)	4
12. I am more irritable and more easily angered.	0	1	2	(3)	4
13. I have to be careful about pacing my physical activities.	0	1	2	3	(4)
14. I am less motivated to do anything that requires physical effort.	0	1	2	3	(4)
15. I am less motivated to engage in social activities.	0	1	2	(3)	4
16. My ability to travel outside my home is limited.	0	(1)	2	3	4
17. I have trouble maintaining physical effort for long periods	0	1	2	3	(4)
18. I find it difficult to make decisions.	0	1	(2)	3	4
19. I have few social contacts outside of my own home.	0	1	(2)	3	4
20. Normal day-to-day events are stressful for me.	0	(1)	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	(2)	3	4
22. I avoid situations that are stressful for me.	0	(1)	2	3	4
23. My muscles feel much weaker than they should.	0	1	2	(3)	4
24. My physical discomfort is increased.	0	1	2	3	(4)
25. I have difficulty dealing with anything new.	0	1	(2)	3	4
26. I am less able to finish tasks that require thinking.	0	1	(2)	3	4
27. I feel unable to meet the demands that people place on me.	0	1	2	(3)	4
28. I am less able to provide financial support for myself and my family.	0	1	2	(3)	4
29. I engage in less sexual activity.	0	(1)	2	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	(3)	4
31. I am less able to complete tasks that require physical effort.	0	1	2	3	(4)
32. I worry about how I look to other people.	0	1	(2)	3	4
33. I am less able to deal with emotional issues.	0	1	(2)	3	4
34. I feel slowed down in my thinking.	0	1	(2)	3	4
35. I find it hard to concentrate.	0	1	2	(3)	4
36. I have difficulty participating fully in family activities.	0	1	2	(3)	4
37. I have to limit my physical activities.	0	1	2	3	(4)
38. I require more frequent and longer periods of rest.	0	1	2	3	(4)
39. I am not able to provide as much emotional support to my family.	0	1	2	3	(4)
40. Minor difficulties seem like major difficulties.	0	1	(2)	3	4

(110)

David S. Bell MD, FAA 440907 018478
77 South Main Street,
Lyndonville, NY 14098
716-765-2099
fax 716-765-2067

FOLLOW UP QUESTIONNAIRE

Name John Magee Date: 5/30/02

1. Please check (√) one of the following statements:

I am free of all fatigue and symptoms	
I am clearly better than I was at the last visit	
I am a little better than I was at the last visit	
I am about the same as I was at the last visit	
I am worse than I was at the last visit	X

2. Please list all medications you are taking:
Celebrex 200mg ½ PO q AM
Glexa 40mg ½ PO q AM
Darocet ½ PO qd PRN

3. Since your last visit here, have you been diagnosed with any other illnesses? no
If yes, please describe:

4. What are your worst three symptoms at present?
Soreness / fatigue / headache

5. Are you working or in school full time, part time, or not at all?
working

6. Is there any significant change in your pattern of symptoms?
seems to be slowly getting worse

Daily Activities: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

activity

a) Total hours sleeping: 8 10

b) Rest, but not sleeping:
(resting, watching TV, light reading, etc) 8 11.75

c) Light to moderate activity:
(shopping, housework, meals, etc): 2

d) Vigorous activity
(exercise, heavy cleaning, sports, etc): .25

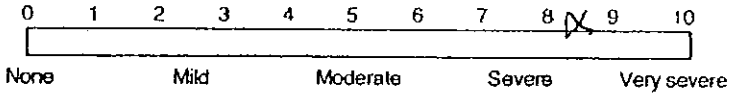
24 hours

(2.25)

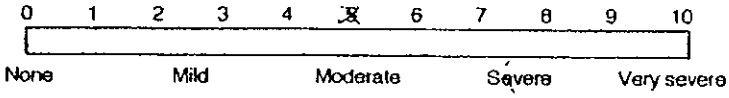
7-1

Symptom Severity: For each of the following symptoms please mark the circle that most closely correlates with the degree of the symptom over the past week.

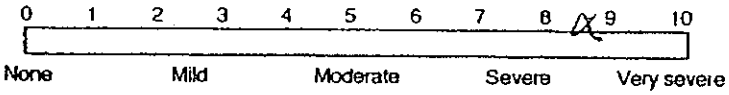
Fatigue



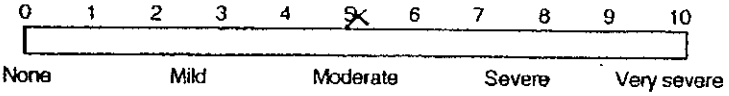
Sore Throat



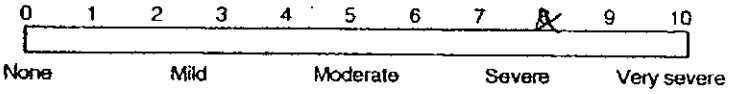
Headache



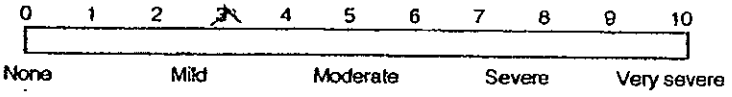
Eye pain and/or light sensitivity



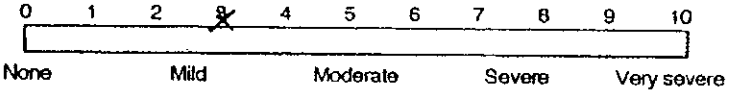
Abdominal Discomfort



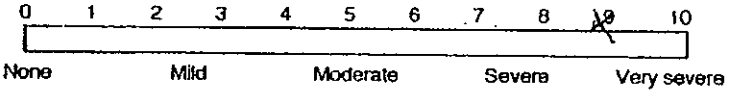
Lymph Node Pain



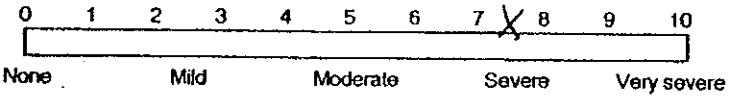
Depression



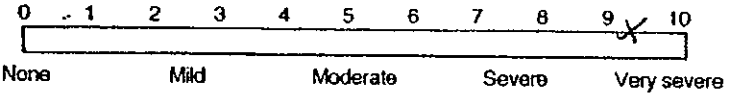
Muscle Pain



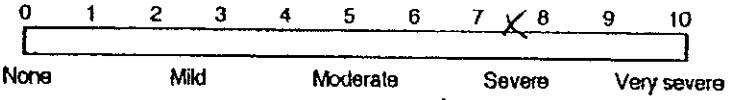
Memory and/or attention problems



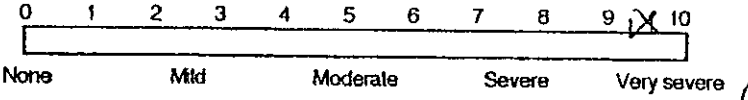
Sleep problems, insomnia, unrefreshing sleep



Dizziness, balance problems, light-headedness



Joint Pain



(68)

7-2

040907 018478

Fatigue Impact Scale.

[Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.]

The following statements are designed to determine how much **impact** fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact at all, 1 for slight impact or problem, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	2	(3)	4
2•. I am more isolated from social contact.	0	(1)	2	3	4
3•. I have to reduce my workload or responsibilities.	0	(1)	2	(3)	4
4•. I am more moody.	0	1	(2)	3	4
5. I have difficulty paying attention for a long period.	0	1	2	(3)	4
6. I feel like I cannot think clearly.	0	1	2	(3)	4
7•. I work less effectively (work inside or outside the home).	0	1	2	3	(4)
8•. I have to rely more on others to help me or do things for me.	0	1	2	(3)	4
9. I have difficulties planning activities ahead of time.	0	(1)	2	3	4
10*. I am more clumsy and uncoordinated.	0	(1)	2	3	4
11. I find that I am more forgetful.	0	1	(2)	3	4
12•. I am more irritable and more easily angered.	0	1	(2)	3	4
13*. I have to be careful about pacing my physical activities.	0	1	2	(3)	4
14*. I am less motivated to do anything that requires physical effort.	0	1	(2)	3	4
15•. I am less motivated to engage in social activities.	0	(1)	2	3	4
16. My ability to travel outside my home is limited.	0	(1)	2	3	4
17*. I have trouble maintaining physical effort for long periods	0	1	2	3	(4)
18. I find it difficult to make decisions.	0	(1)	2	3	4
19•. I have few social contacts outside of my own home.	0	(1)	2	3	4
20•. Normal day-to-day events are stressful for me.	0	(1)	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	(2)	3	4
22•. I avoid situations that are stressful for me.	0	(1)	2	3	4
23*. My muscles feel much weaker than they should.	0	1	2	(3)	4
24*. My physical discomfort is increased.	0	1	2	(3)	4
25•. I have difficulty dealing with anything new.	0	(1)	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	(2)	3	4
27•. I feel unable to meet the demands that people place on me.	0	1	(2)	3	4
28•. I am less able to provide financial support for myself and my family.	0	1	(2)	3	4
29•. I engage in less sexual activity.	0	1	(2)	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	(2)	3	4
31*. I am less able to complete tasks that require physical effort.	0	1	2	3	(4)
32*. I worry about how I look to other people.	0	1	(2)	3	(4)
33•. I am less able to deal with emotional issues.	0	1	(2)	3	4
34. I feel slowed down in my thinking.	0	1	2	3	(4)
35. I find it hard to concentrate.	0	1	2	3	(4)
36•. I have difficulty participating fully in family activities.	0	1	2	3	(4)
37*. I have to limit my physical activities.	0	1	2	3	(4)
38*. I require more frequent and longer periods of rest.	0	1	2	(3)	4
39. I am not able to provide as much emotional support to my family.	0	1	2	(3)	4
40. Minor difficulties seem like major difficulties.	0	1	2	(3)	4

(95)

7-3

Activity / Disability Scale: Pleas[illegible] a checkmark (√) next to the number "[illegible]most closely describe[illegible] your symptoms and activity. You ma[illegible]heck between categories but place o[illegible]heckmark only.

_____100: No symptoms at rest; no symptoms with exercise; normal overall activity level; able to work full time without difficulty.

_____90: No symptoms at rest; mild symptoms with activity; normal overall activity level; able to work full time without difficulty.

_____80: Mild symptoms at rest; symptoms worsened by exertion; minimal activity restriction noted for activities requiring exertion only; able to work full time but difficulty in jobs requiring exertion.

_____70: Mild symptoms at rest; some daily activity limitation clearly noted; overall functioning close to 90% of expected except for activities requiring exertion; able to work full time with difficulty.

_____60: Mild to moderate symptoms at rest; daily activity limitation clearly noted; overall functioning 70% of expected; unable to sustain vigorous activity, but able to work full time in light activity.

_____50: Moderate symptoms at rest; moderate to severe symptoms with exercise; overall activity level reduced to 50% of expected; able to be out of house for 2 to 3 hours daily; unable to perform strenuous duties, but able to perform light duty or desk work 4-5 hours a day.

_____40: Moderate symptoms at rest; moderate to severe symptoms with exercise or activity; overall activity level reduced to 50% of expected; not confined to house, but unable to perform strenuous duties; able to perform light duty or desk work 3-4 hours a day with rest periods.

_____30: Moderate to severe symptoms at rest; severe symptoms with any exercise; overall activity level reduced to less than 50% of expected; usually confined to house; unable to perform strenuous tasks, but able to perform desk work 2-3 hours a day, with rest periods.

_____20: Moderate to severe symptoms at rest; unable to perform strenuous activity; overall activity 30% of expected; unable to leave house except rarely; confined to bed most of day.

_____10: Severe symptoms at rest; bed ridden the majority of the time; [illegible]re travel outside of the house; able to perform self care needs.

_____0: Severe symptoms on a continuous basis; bed ridden constantly; unable to care for self

For Office Use Only:

Hours activity (H, 1-10)	_____	weighted score = 10-H:	_____
VAS (0-120)	_____	weighted score = VAS / 12	_____
Fisk (F, 0-160)	_____	weighted score (F / 16)	_____
Modified Karnofsky (MK, 0-100)	_____	weighted score (10 - MK/ 10)	_____
		total	_____

CFS Severity Score (total / 4): _____

7-4

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Lyndonville, NY 14098
716-765-2099
fax 716-765-2067

040907 018478

FOLLOW UP QUESTIONNAIRE

Name John Magee Date: 11/9/00

1. Please check (√) one of the following statements:

I am free of all fatigue and symptoms	
I am clearly better than I was at the last visit	
I am a little better than I was at the last visit	
I am about the same as I was at the last visit	X
I am worse than I was at the last visit	

2. Please list all medications you are taking:
Celexa 40mg
Celebrex 200mg

3. Since your last visit here, have you been diagnosed with any other illnesses? no
If yes, please describe:

4. What are your worst three symptoms at present?
headache fatigue
Aches

5. Are you working or in school full time, part time, or not at all? full time

6. Is there any significant change in your pattern of symptoms? no

Daily Activities: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

activity

a) Total hours sleeping: 8-9

b) Rest, but not sleeping:
(resting, watching TV, light reading, etc) 5

c) Light to moderate activity:
(shopping, housework, meals, etc): 10

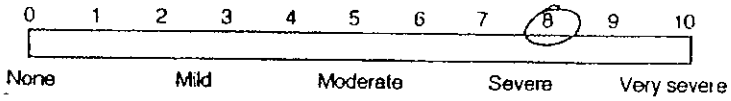
d) Vigorous activity
(exercise, heavy cleaning, sports, etc):

24 hours (10)

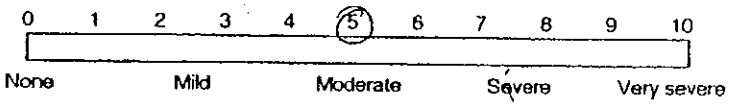
7-1

Symptom Severity: For each of following symptoms please mark the .e that most closely correlates with the degree of the . .iptom over the past week.

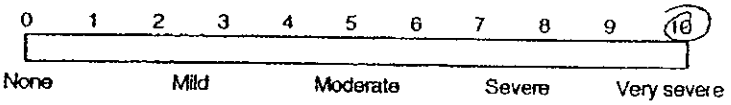
Fatigue



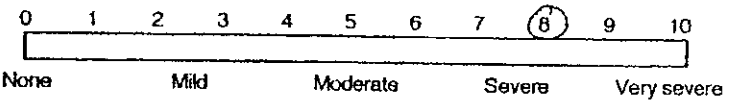
Sore Throat



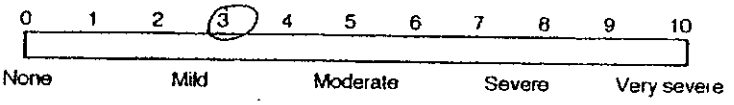
Headache



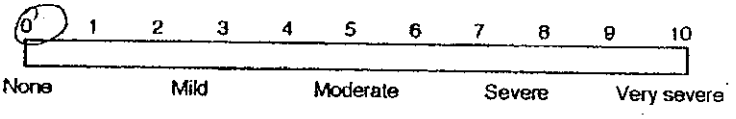
Eye pain and/or light sensitivity



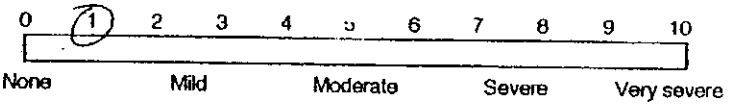
Abdominal Discomfort



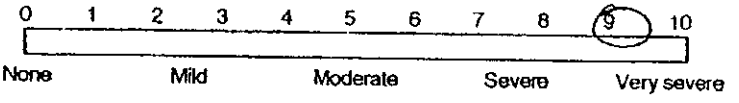
Lymph Node Pain



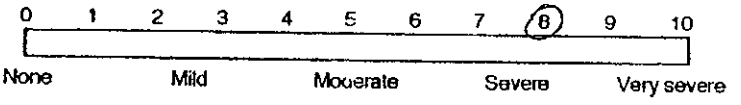
Depression



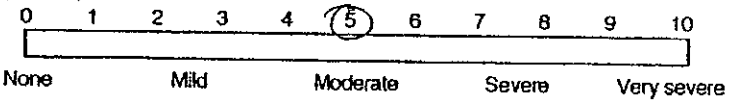
Muscle Pain



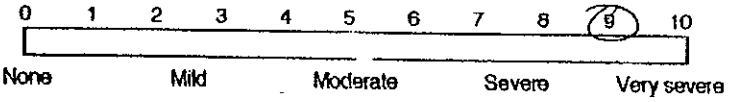
Memory and/or attention problems



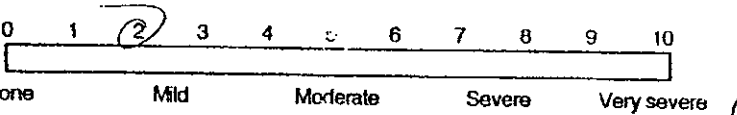
Sleep problems, insomnia, unrefreshing sleep



Dizziness, balance problems, light-headedness



Joint Pain



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7-2

040907 018478

Fatigue Impact Scale.

[Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.]

The following statements are designed to determine how much **impact** fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact at all, 1 for slight impact or problem, 2 for moderate impact, 3 for a big impact, and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	2	3	4
2•. I am more isolated from social contact.	0	1	2	3	4
3•. I have to reduce my workload or responsibilities.	0	1	2	3	4
4•. I am more moody.	0	1	2	3	4
5. I have difficulty paying attention for a long period.	0	1	2	3	4
6. I feel like I cannot think clearly.	0	1	2	3	4
7•. I work less effectively (work inside or outside the home).	0	1	2	3	4
8•. I have to rely more on others to help me or do things for me.	0	1	2	3	4
9. I have difficulties planning activities ahead of time.	0	1	2	3	4
10*. I am more clumsy and uncoordinated.	0	1	2	3	4
11. I find that I am more forgetful.	0	1	2	3	4
12•. I am more irritable and more easily angered.	0	1	2	3	4
13*. I have to be careful about pacing my physical activities.	0	1	2	3	4
14*. I am less motivated to do anything that requires physical effort.	0	1	2	3	4
15•. I am less motivated to engage in social activities.	0	1	2	3	4
16. My ability to travel outside my home is limited.	0	1	2	3	4
17*. I have trouble maintaining physical effort for long periods	0	1	2	3	4
18. I find it difficult to make decisions.	0	1	2	3	4
19•. I have few social contacts outside of my own home.	0	1	2	3	4
20•. Normal day-to-day events are stressful for me.	0	1	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	2	3	4
22•. I avoid situations that are stressful for me.	0	1	2	3	4
23*. My muscles feel much weaker than they should.	0	1	2	3	4
24*. My physical discomfort is increased.	0	1	2	3	4
25•. I have difficulty dealing with anything new.	0	1	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	2	3	4
27•. I feel unable to meet the demands that people place on me.	0	1	2	3	4
28•. I am less able to provide financial support for myself and my family.	0	1	2	3	4
29•. I engage in less sexual activity.	0	1	2	3	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	3	4
31*. I am less able to complete tasks that require physical effort.	0	1	2	3	4
32*. I worry about how I look to other people.	0	1	2	3	4
33•. I am less able to deal with emotional issues.	0	1	2	3	4
34. I feel slowed down in my thinking.	0	1	2	3	4
35. I find it hard to concentrate.	0	1	2	3	4
36•. I have difficulty participating fully in family activities.	0	1	2	3	4
37*. I have to limit my physical activities.	0	1	2	3	4
38*. I require more frequent and longer periods of rest.	0	1	2	3	4
39. I am not able to provide as much emotional support to my family.	0	1	2	3	4
40. Minor difficulties seem like major difficulties.	0	1	2	3	4

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7-3

Activity / Disability Scale: Ple[illegible]put a checkmark (√) next to the numb[illegible]at most closely describes your symptoms and activity. You m[illegible]y check between categories but place o[illegible]e checkmark only.

_____100: No symptoms at rest; no symptoms with exercise; normal overall activity level; able to work full time without difficulty.

_____90: No symptoms at rest; mild symptoms with activity; normal overall activity level; able to work full time without difficulty.

_____80: Mild symptoms at rest; symptoms worsened by exertion; minimal activity restriction noted for activities requiring exertion only; able to work full time but difficulty in jobs requiring exertion.

_____70: Mild symptoms at rest; some daily activity limitation clearly noted; overall functioning close to 90% of expected except for activities requiring exertion; able to work full time with difficulty.

_____60: Mild to moderate symptoms at rest; daily activity limitation clearly noted; overall functioning 70% of expected; unable to sustain vigorous activity, but able to work full time in light activity.

_____50: Moderate symptoms at rest; moderate to severe symptoms with exercise; overall activity level reduced to 50% of expected; able to be out of house for 2 to 3 hours daily; unable to perform strenuous duties, but able to perform light duty or desk work 4-5 hours a day.

__X__40: Moderate symptoms at rest; moderate to severe symptoms with exercise or activity; overall activity level reduced to 50% of expected; not confined to house, but unable to perform strenuous duties; able to perform light duty or desk work 3-4 hours a day with rest periods.

_____30: Moderate to severe symptoms at rest; severe symptoms with any exercise; overall activity level reduced to less than 50% of expected; usually confined to house; unable to perform strenuous tasks, but able to perform desk work 2-3 hours a day, with rest periods.

_____20: Moderate to severe symptoms at rest; unable to perform strenuous activity; overall activity 30% of expected; unable to leave house except rarely; confined to bed most of day.

_____10: Severe symptoms at rest; bed ridden the majority of the time; rare travel outside of the house; able to perform self care needs.

_____0: Severe symptoms on a continuous basis; bed ridden constantly; unable to care for self

For Office Use Only:

Hours activity (H, 1-10)	_____	weighted score = 10-H:	_____
VAS (0-120)	_____	weighted score = VAS / 12	_____
Fisk (F, 0-160)	_____	weighted score (F / 16)	_____
Modified Kamofsky (MK, 0-100)	_____	weighted score (10 - MK/ 10)	_____
		total	_____

CFS Severity Score (total / 4): _____

7-4

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77 South Main Street,
Lyndonville, NY 14098
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fax 716-765-2067

FOLLOW UP QUESTIONNAIRE

Name John Mayer Date: 10/9/06

1. Please check (√) one of the following statements:

I am free of all fatigue and symptoms	
I am clearly better than I was at the last visit	
I am a little better than I was at the last visit	
I am about the same as I was at the last visit	X
I am worse than I was at the last visit	

2. Please list all medications you are taking:
Celexa - 40mg/day Ultram
Celebrex - 200mg/day Azopt

3. Since your last visit here, have you been diagnosed with any other illnesses? no
If yes, please describe:

4. What are your worst three symptoms at present?
Fatigue, soreness, headaches

5. Are you working or in school full time, part time, or not at all? full time

6. Is there any significant change in your pattern of symptoms? no

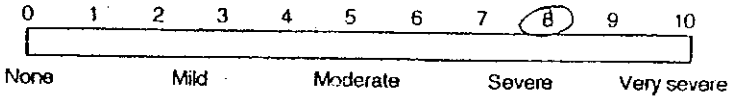
Daily Activities: Please list the number of hours spent in each of the following categories for an average day during the past week (total should add to 24 hours):

activity	
a) Total hours sleeping:	8
b) Rest, but not sleeping: (resting, watching TV, light reading, etc)	7
c) Light to moderate activity: (shopping, housework, meals, etc):	9
d) Vigorous activity (exercise, heavy cleaning, sports, etc):	
24 hours	(9)

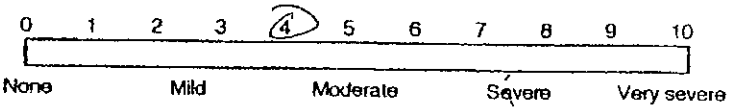
7-1

Symptom Severity: For each of the following symptoms please mark the circle that most closely correlates with the degree of the symptom over the past week.

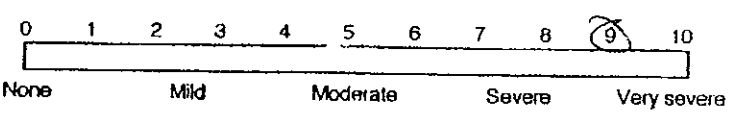
Fatigue



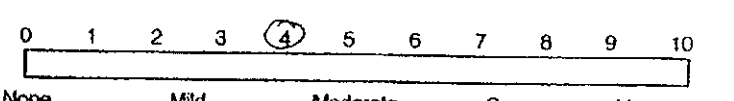
Sore Throat



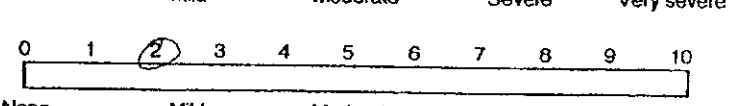
Headache



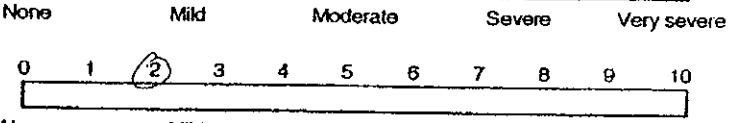
Eye pain and/or light sensitivity



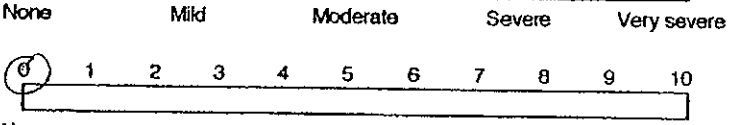
Abdominal Discomfort



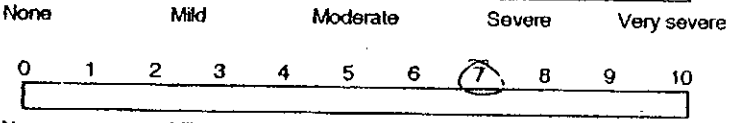
Lymph Node Pain



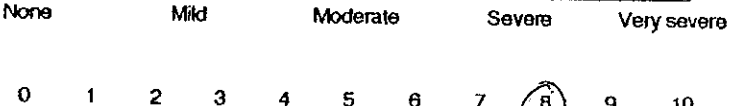
Depression



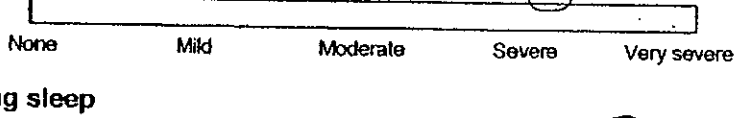
Muscle Pain



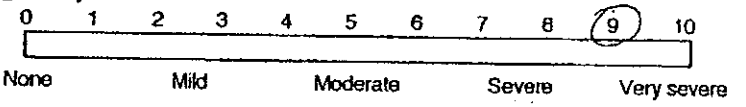
Memory and/or attention problems



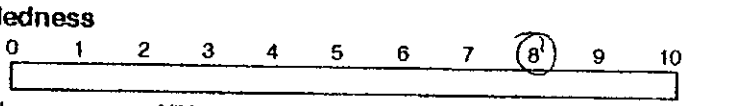
Sleep problems, insomnia, unrefreshing sleep



Dizziness, balance problems, light-headedness



Joint Pain



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7-2

040907 018478

Fatigue Impact Scale.

[Fisk JD and co-workers. C I D.1994;18(Suppl 1):S79-S83.]

The following statements are designed to determine how much **impact** fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact at all, 1 for slight impact or problem, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

1. I feel less alert.	0	1	2	(3)	4
2•. I am more isolated from social contact.	0	1	(2)	3	4
3•. I have to reduce my workload or responsibilities.	0	1	2	(3)	4
4•. I am more moody.	0	(1)	2	3	4
5. I have difficulty paying attention for a long period.	0	1	(2)	3	4
6. I feel like I cannot think clearly.	0	1	2	(3)	4
7•. I work less effectively (work inside or outside the home).	0	1	2	(3)	4
8•. I have to rely more on others to help me or do things for me.	0	1	2	(3)	4
9. I have difficulties planning activities ahead of time.	0	(1)	2	3	4
10*. I am more clumsy and uncoordinated.	0	1	(2)	3	4
11. I find that I am more forgetful.	0	1	2	(3)	4
12•. I am more irritable and more easily angered.	(0)	1	2	3	4
13*. I have to be careful about pacing my physical activities.	0	1	2	(3)	4
14*. I am less motivated to do anything that requires physical effort.	0	1	2	(3)	4
15•. I am less motivated to engage in social activities.	0	(1)	2	3	4
16. My ability to travel outside my home is limited.	0	(1)	2	3	4
17*. I have trouble maintaining physical effort for long periods	0	1	2	(3)	4
18. I find it difficult to make decisions.	(0)	1	2	3	4
19•. I have few social contacts outside of my own home.	0	1	(2)	3	4
20•. Normal day-to-day events are stressful for me.	0	(1)	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	2	(3)	4
22•. I avoid situations that are stressful for me.	0	(1)	2	3	4
23*. My muscles feel much weaker than they should.	0	1	2	(3)	4
24*. My physical discomfort is increased.	0	1	(2)	3	4
25•. I have difficulty dealing with anything new.	0	(1)	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	(2)	3	4
27•. I feel unable to meet the demands that people place on me.	0	1	(2)	3	4
28•. I am less able to provide financial support for myself and my family.	0	(1)	2	3	4
29•. I engage in less sexual activity.	0	(1)	2	(3)	4
30. I find it difficult to organize my thoughts when I am doing things.	0	1	2	(3)	4
31*. I am less able to complete tasks that require physical effort.	0	1	2	(3)	4
32*. I worry about how I look to other people.	0	(1)	2	3	4
33•. I am less able to deal with emotional issues.	0	(1)	2	3	4
34. I feel slowed down in my thinking.	0	1	2	(3)	4
35. I find it hard to concentrate.	0	1	2	(3)	4
36•. I have difficulty participating fully in family activities.	0	1	(2)	3	4
37*. I have to limit my physical activities.	0	1	2	(3)	4
38*. I require more frequent and longer periods of rest.	0	1	(2)	3	4
39. I am not able to provide as much emotional support to my family.	0	1	(2)	3	4
40. Minor difficulties seem like major difficulties.	0	(1)	2	3	4

80

7-3

Activity / Disability Scale: Ple[illegible]put a checkmark (√) next to the numb[illegible]at most closely describes your symptoms and activity. You [illegible]y check between categories but place [illegible] checkmark only.

_____100: No symptoms at rest; no symptoms with exercise; normal overall activity level; able to work full time without difficulty.

_____90: No symptoms at rest; mild symptoms with activity; normal overall activity level; able to work full time without difficulty.

_____80: Mild symptoms at rest; symptoms worsened by exertion; minimal activity restriction noted for activities requiring exertion only; able to work full time but difficulty in jobs requiring exertion.

_____70: Mild symptoms at rest; some daily activity limitation clearly noted; overall functioning close to 90% of expected except for activities requiring exertion; able to work full time with difficulty.

_____60: Mild to moderate symptoms at rest; daily activity limitation clearly noted; overall functioning 70% of expected; unable to sustain vigorous activity, but able to work full time in light activity.

_____50: Moderate symptoms at rest; moderate to severe symptoms with exercise; overall activity level reduced to 50% of expected; able to be out of house for 2 to 3 hours daily; unable to perform strenuous duties, but able to perform light duty or desk work 4-5 hours a day.

__✓__40: Moderate symptoms at rest; moderate to severe symptoms with exercise or activity; overall activity level reduced to 50% of expected; not confined to house, but unable to perform strenuous duties; able to perform light duty or desk work 3-4 hours a day with rest periods.

_____30: Moderate to severe symptoms at rest; severe symptoms with any exercise; overall activity level reduced to less than 50% of expected; usually confined to house; unable to perform strenuous tasks, but able to perform desk work 2-3 hours a day, with rest periods.

_____20: Moderate to severe symptoms at rest; unable to perform strenuous activity; overall activity 30% of expected; unable to leave house except rarely; confined to bed most of day.

_____10: Severe symptoms at rest; bed ridden the majority of the time; rare travel outside of the house; able to perform self care needs.

_____0: Severe symptoms on a continuous basis; bed ridden constantly; unable to care for self

For Office Use Only:

Hours activity (H, 1-10)	_____	weighted score = 10-H:	_____
VAS (0-120)	_____	weighted score = VAS / 12	_____
Fisk (F, 0-160)	_____	weighted score (F / 16)	_____
Modified Kamofsky (MK, 0-100)	_____	weighted score (10 - MK/ 10)	_____
		total	_____

CFS Severity Score (total / 4): _____

7-4

040907.018478

David S. Bell MD, FAAP
Chronic Fatigue Syndrome Clin.
77 South Main Street,
Lyndonville, NY 14098

DATE: 9/18/00

Chronic Fatigue Syndrome (CFIDS) Questionnaire

Name: John Magee Age: 40

Address: 3520 Rush-Mendon Rd

Home Tel: (716) 624-9306 Work Tel: (716) 726-4264 Date of Birth: 12/07/59

Insurance Company: Strong Care Card #: 088-54-4213

Subscriber's Name: John Magee Group Name: _____

Name and address of primary care physician:

Dr. Margaret Bergin
200 White Spruce Blvd
Rochester NY 14623

1. When do you think that your illness began?

2. Did you become ill suddenly? (Y/N) N

Have you been ill since that time? (Y/ N) Y

3. Prior to you illness, were you very active? (Y/ N) Y

If yes, list activities you were engaged in (sports, hiking, etc:)

4. Was fatigue the first symptom of your illness that you noticed? (Y/ N) Y leg fatigue

if no, what was the first symptom(s)?

5. When were you the most ill with fatigue and other symptoms (What month and year)?

6. What are your worst three symptoms at present?

a) headaches b) fatigue no endurance c) body aches or "soreness"

7. At the present time, do you think you are improving? (Y/ N) N improved some since before starting celebrex but not since after.

8. List the medications you are currently taking:

Celebrex 200
Celexa 40
Tried B12 - nothing, Q10

Past Medical History

1. Have you been diagnosed with any illnesses before you became ill with your present condition? (Y/N) _____ If yes, please describe:

2. Have you had any unusual illnesses prior to this illness? (Y/ N) _____ If yes, please describe:

glaucoma

3. Have you ever had a blor ansfusion? (Y/ N) N
4. Have you ever had a he njury or concussion? (Y/ N) N yes give date:
5. Have you ever been exposed to toxic chemical(s)? (Y/ N) Y If yes give date: Methylchloride
6. Have you ever used drugs or alcohol to excess? (Y/ N) N
7. Have you ever been hospitalized? (Y/ N) Y
8. Please list medications you are allergic or intollerant to:
Co

Family History

1. Do any family members have symptoms of CFS or fibromyalgia? (Y/ N) N
2. Do any relatives have MS no ? Lupus no ? Rheumatoid athritis no ?
3. Please list name, age and health status of all persons living in your family:
mom 77 Heart disease ↑ BP ↑ Chlesterol
Dad 77 diabetes
3 sisters 51 46 43 good health

IV. Daily Activities

1. Please list the number of hours spent in each of the following categories for an average day, "good" day, and "bad" day during the past month (total for each should add to 24 hours):

activity	Average Day	"Good" day	"Bad" day
a) Total hours sleeping:	7	6	12
b) Rest, but not sleeping:	0		
c) Light activity while sitting or lying down: (reading, watching TV, etc):	6	3	12
e) Moderate activities about house (light cleaning, desk work, etc):	0	3 BM	
f) Moderate activities out of house (work, walking, driving, shopping, etc):	11	16	
g)Vigorous activities (exercise, heavy cleaning, sports, etc):	0	2	0
	24 hours	24 hours	24 hours

(11)

How many days of the past month would you consider "average"? 22
How many days of the past month would you consider "good"? 4
How many days of the past month would you consider "bad"? 4

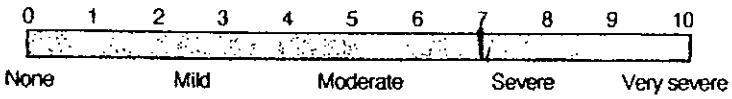
Work / School

1. What is your occupation? Quality Engineer / Lawyer
2. Do you presently work or go to school full time? (Y/ N) Y
If no, when were you last full time?
4. Do you presently work or go to school part time? (Y/ N) Y
If yes, how many hours per week?
5. Are you unable to work or go to school at the present time? (Y/(N)
If yes, when did you first become disabled?

Symptoms

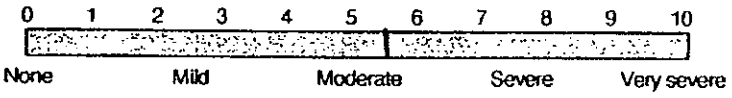
For each of the following symptoms please mark the scale that most closely correlates with the degree of the symptom severity over the past month.

Fatigue ✓ feels like finished marathon — not sleep



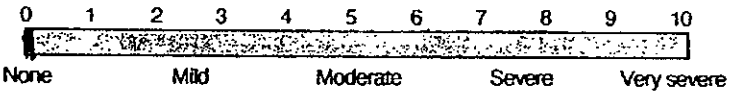
1. When did you first notice continuous fatigue? 5 yrs.
2. During a typical day, are you ever completely free of fatigue? (Y/N) no
3. Does the fatigue disappear completely with rest? (Y/N) no
4. Is the fatigue worsened by exertion? (Y/N) yes
5. Does fatigue limit your activities? (Y/N) yes If yes, when did this start? 5 yrs.
6. Do you now have to rest following previously tolerated activities? (Y/N) yes crash

Sore Throat ✓



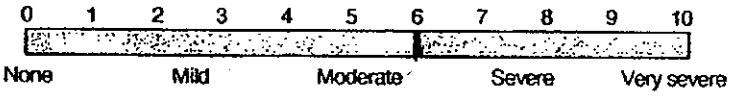
3/month lasts 2 day 1 wk

Lymph Node Pain ✓



1. Do you have swelling of the lymph nodes? (Y/N) no
2. What nodes give you the most difficulty?

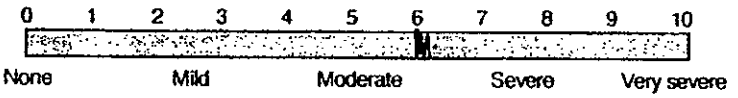
Eye Pain, Light sensitivity eye Dr. said not due to glaucoma



⊕ odor paint makes sick- light

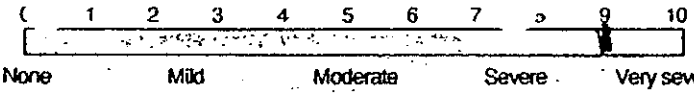
1. Do your eyes hurt? (Y/N) yes
2. Do you ever have double vision? (Y/N) no
3. Do you have blurry vision frequently? (Y/N) no

Abdominal Discomfort



1. Do you have abdominal pain? (Y/N) no
2. Do you have frequent nausea? (Y/N) yes — daily
3. Do you have frequent diarrhea? (Y/N) no
4. Do you have frequent constipation? (Y/N) no takes Imms

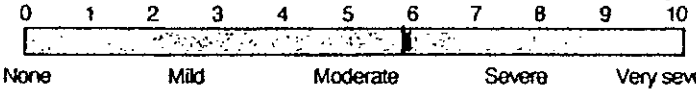
Muscle Pain ✓



1. Do you have muscle weakness? (Y/ N) yes
2. Do you have muscle stiffness (Y/ N) yes
3. Do you have frequent backache? (Y/ N) yes
4. What muscle groups give you the most difficulty? Legs

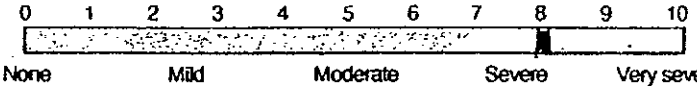
nerve conduction ✓ ? lost some sensory comp muscle bx- normal no info

Joint Pain ✓



1. Do you have swelling in your joints? (Y/ N) no
2. Do your joints become hot and/or red? (Y/ N) no
3. Do you have morning stiffness? (Y/ N) yes
4. What joints give you the most discomfort? neck

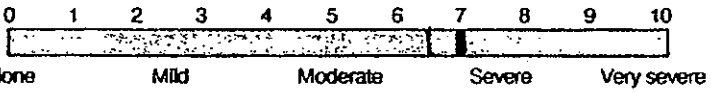
Headache ✓



1. Do you have a headache every day? (Y/N) yes
2. Is your headache primarily a pressure sensation? (Y/ N) yes
3. Do you have headache in the back of the head? (Y/ N) yes

occipital voices in society

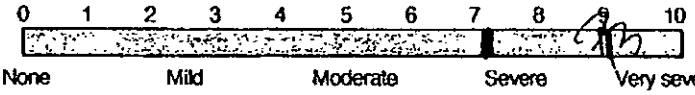
Memory / Attention ✓



1. Do you have difficulty with short term memory? (Y/ N) yes
   If yes, when did it begin? 3 yrs. ago
2. Do you have difficulty with long term (distant) memory? (Y/ N) no
3. Do you have difficulty with attention? (Y/ N) no If yes, when did it begin?
4. Do you have difficulty with noisy distractions? (Y/ N) no
5. Are your attention and memory symptoms related to how tired you feel?(Y/ N) no
6. Are you able to read as well as before you became ill? (Y/ N) no
7. Are you able to drive a car? (Y/ N) yes
8. Please give recent examples of your memory and concentration difficulties:

At work ~~rem~~ not being able to find the right phrase or word or Peoples names some word finding

Dizziness, Balance disturbance, Numbness, Balance Problems ✓



stiffness better with shower
tired with bath

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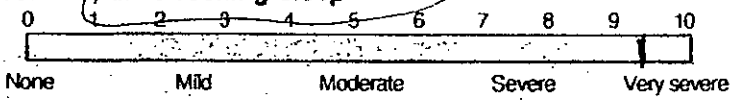
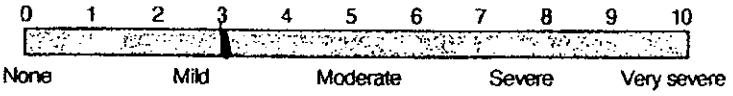
Sleep Disturbance, Inso[illegible], unrefreshing sleep



1. How long does it take you to get to sleep at night? 15 min
2. At what time do you usually get up? 6 am
3. Do you wake more easily than before you were sick? (Y/ N) no
4. Do you have jerking motions as you fall asleep? (Y/ N) no
5. Do your legs jerk as you are going to sleep? (Y/ N) no
6. Do you have overwhelming sleepiness that comes on suddenly? (Y/ N) no
7. Do you have excessive snoring? (Y/ N) no

frequent waking

Depression



1. Before you developed fatigue, did you ever had a serious emotional illness? (Y/ N) no
2. Before you developed your present illness, have you been treated for depression or other emotional problems? (Y/ N) no
3. Have you ever been hospitalized for emotional symptoms? (Y/ N) no
   If yes please give dates:
4. Do you have panic attacks? (Y/ N) no
5. Are you currently receiving counseling? (Y/ N) no

Other

1. Do you have frequent fever over 100°? (Y/ N) no
2. Do you frequently have the sensation of fever? (Y/ N) yes
3. Do you have frequent chills? (Y/ N) yes
4. Do you have night sweats? (Y/ N) yes! — every night
5. Do you hav frequent flushing rash on the face? (Y/ N) no
6. Do you have frequent symptoms of urinary infections? (Y/ N) no
7. Do you have bladder pain? (Y/ N) no
8. Do you have chronic caugh? (Y/ N) no
9. Have you developed allergies since you became ill? (Y/ N) yes — seafood
10. Have you developed asthma since you became ill? (Y/ N) no
11. Have you developed chemical sensitivities since you became ill? (Y/ N) yes
12. Do you have episodes of shortness of breath? (Y/ N) no
13. Do you have episodes of palpitations? (Y/ N) no
14. Do you have excessive thirst? (Y/ N) no
15. How many 8 oz glasses of liquid do you drink daily? 6
16. Do you crave salt? no

2 coffee

Overall Activity Scale

At what level have you been functioning in the past few weeks compared to what you would be able to do if you were healthy? (Circle one)

10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Activity / Disability Scale:

Please put a checkmark (√) next to the number that most closely describes your symptoms and activity. You may check between categories but place one checkmark only.

_____100: No symptoms at rest; No symptoms with exercise; Normal overall activity level; Able to work full time without difficulty.

_____90: No symptoms at rest; Mild symptoms with activity; Normal overall activity level; Able to work full time without difficulty.

_____80: Mild symptoms at rest; symptoms worsened by exertion; minimal activity restriction noted for activities requiring exertion only; able to work full time with difficulty in jobs requiring exertion.

_____70: Mild symptoms at rest; some daily activity limitation clearly noted. Overall functioning close to 90% of expected except for activities requiring exertion. Able to work full time with difficulty.

_____60: Mild to moderate symptoms at rest; daily activity limitation clearly noted. Overall functioning 70% to 90%. Unable to work full time in jobs requiring physical labor, but able to work full time in light activity if hours flexible.

_____50: Moderate symptoms at rest. Moderate to severe symptoms with exercise or activity; overall activity level reduced to 70% of expected. Unable to perform strenuous duties, but able to perform light duty or desk work 4-5 hours a day, but requires rest periods.

_____40: Moderate symptoms at rest. Moderate to severe symptoms with exercise or activity; overall activity level reduced to 50%-70% of expected. Not confined to house.Unable to perform strenuous duties; able to perform light duty or desk work 3-4 hours a day, but requires rest periods.

_____30: Moderate to severe symptoms at rest. Severe symptoms with any exercise; overall activity level reduced to 50% of expected. Usually confined to house. Unable to perform any strenuous tasks. Able to perform desk work 2-3 hours a day, but requires rest periods.

_____20: Moderate to severe symptoms at rest. Unable to perform strenuous activity; Overall activity 30%-50% of expected. Unable to leave house except rarely; Confined to bed most of day; Unable to concentrate for more than 1 hour a day.

_____10: Severe symptoms at rest; Bed ridden the majority of the time. No travel outside of the house. Marked cognitive symptoms preventing concentration.

_____0: Severe symptoms on a continuous basis; Bed ridden constantly; unable to care for self

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Fatigue Impact Scale.

The following statements are designed to determine how much **impact** fatigue has had on your life in the past month. Please indicate the most appropriate response for each statement below by circling 0 for no impact at all, 1 for slight impact or problem, 2 for moderate impact, 3 for a big impact; and 4 for a very severe impact or problem.

	None	Small	Moderate	Big	Extreme
1. I feel less alert.	0	1	(2)	3	4
2. I am more isolated from social contact.	0	(1)	2	3	4
3. I have to reduce my workload or responsibilities.	0	1	(2)	3	4
4. I am more moody.	(0)	1	(2)	3	4
5. I have difficulty paying attention for a long period.	0	1	(2)	3	4
6. I feel like I cannot think clearly.	0	1	2	(3)	4
7. I work less effectively (work inside or outside the home).	0	1	2	(3)	4
8. I have to rely more on others to help me or do things for me.	0	1	(2)	3	4
9. I have difficulties planning activities ahead of time.	0	(1)	2	3	4
10. I am more clumsy and uncoordinated.	0	(1)	2	3	4
11. I find that I am more forgetful.	0	1	(2)	3	4
12. I am more irritable and more easily angered.	(0)	1	2	3	4
13. I have to be careful about pacing my physical activities.	0	1	2	(3)	4
14. I am less motivated to do things that require physical effort.	0	1	2	(3)	4
15. I am less motivated to engage in social activities.	0	1	(2)	3	4
16. My ability to travel outside my home is limited.	0	(1)	2	3	4
17. I have trouble maintaining physical effort for long periods	0	1	2	3	(4)
18. I find it difficult to make decisions.	0	(1)	2	3	4
19. I have few social contacts outside of my own home.	(0)	1	2	3	4
20. Normal day-to-day events are stressful for me.	(0)	1	2	3	4
21. I am less motivated to do anything that requires thinking.	0	1	(2)	3	4
22. I avoid situations that are stressful for me.	(0)	1	2	3	4
23. My muscles feel much weaker than they should.	0	1	2	3	(4)
24. My physical discomfort is increased.	0	1	2	3	(4)
25. I have difficulty dealing with anything new.	(0)	1	2	3	4
26. I am less able to finish tasks that require thinking.	0	1	(2)	3	4
27. I feel unable to meet the demands that people place on me.	0	1	(2)	3	4
28. I am less able to provide financial support.	(0)	1	2	3	4
29. I engage in less sexual activity.	(0)	1	2	3	4
30. I find it difficult to organize my thoughts.	0	1	2	(3)	4
31. I am less able to complete tasks that require physical effort.	0	1	2	3	(4)
32. I worry about how I look to other people.	(0)	1	2	3	4
33. I am less able to deal with emotional issues.	(0)	1	2	3	4
34. I feel slowed down in my thinking.	0	1	2	3	(4)
35. I find it hard to concentrate.	0	1	2	(3)	4
36. I have difficulty participating fully in family activities.	0	1	2	(3)	4
37. I have to limit my physical activities.	0	1	2	(3)	4
38. I require more frequent and longer periods of rest.	0	1	2	(3)	4
39. I am unable to provide emotional support to my family.	(0)	1	2	3	4
40. Minor difficulties seem like major difficulties.	(0)	1	2	3	4

70

20/50

I-8

Modified Depression Inventory

This questionnaire consists of 17 groups of statements. After reading each group of four statements (0, 1, 2, or 3), choose the one statement of the group that best describes the way you have been feeling in the past week. Place a circle aroung the number corresponding to that statement. Please circle one answer for each group of statements. Thank you very much.

(0) I do not feel sad
1 I feel sad
2 I am sad all the time and I can't snap out of it
3 I am so sad I can't stand it

0 I am not discouraged about the future
(1) I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless

(0) I do not feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life, all I can see is a lot of failure
3 I feel I am a complete failure as a person

0 I get as much satisfaction out of things as I used to.
(1) I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

(0) I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

(0) I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished

(0) I don't feel disappointed in myself.
1 I am disappointed in myself
2 I am disgusted with myself.
3 I hate myself.

(0) I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

(0) I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

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(0) I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

(0) I am no more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.

(0) I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all my interest in other people.

(0) I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
(2) I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

0 My appetite is no worse than usual.
(1) My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

(0) I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

(0) I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

(5)

Metropolitan Life Insurance Company
MetLife Disability, P O Box 14590, Lexington, KY 40511-4590
Phone: 1-800-300-4296 **Fax:** 1-800-230-9531

MetLife®

September 2, 2004

Mr. John Magee
71 Ontario St
Honeoye Falls, NY 14472-1123

RE: Employer: ITT INDUSTRIES
Claim #: 640407128904
Employee ID #: 620820

Dear Mr. Magee:

We previously notified you of the information required for your disability benefit. Our records reflect this has not been provided. Since this has not been received, your claim is being closed as of December 31, 2024.

You may appeal this decision by sending a written request for appeal to within 180 days after you receive this denial letter. Please include in your appeal letter the reason(s) you believe the claim was improperly denied, and submit the previously requested information as well as any additional comments, documents, records or other information relating to your claim that you deem appropriate for us to give your appeal proper consideration. Upon request, MetLife will provide you with a copy of the documents, records, or other information we have that are relevant to your claim.

MetLife will evaluate all the information and advise you of our determination of your appeal within 45 days after we receive your written request for appeal. If there are special circumstances requiring additional time to complete our review, we may take up to an additional 45 days, but only after notifying you of the special circumstances in writing. In the event your appeal is denied in whole or in part, you will have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

If you have any questions, please contact MetLife's Customer Response Center Monday through Friday from 8 a.m. to 8 p.m. Eastern Time at the toll free number above. The Customer Response Center representatives can assist you with most claim questions.

Sincerely,

Peter Knoth
MetLife Disability

For efficient and prompt claim handling, all documents or correspondence returned to us should contain the claim number.

040823 013664

July 13 2004

JOHN MAGEE
71 ONTARIO ST
HONEOYE FALLS, NY 14472

Re: Kodak Long-Term Disability (LTD) application
Kodak No.: 620820
Claim No.: 640407128904

In order to file a claim for Kodak LTD benefits, the enclosed Employer's Statement must be completed by either the Supervisor or the Human Resource Representative of the claimant and returned to MetLife as soon as possible.

Please be sure to complete the form in its entirety. Also, please complete the following information so that MetLife may contact you if additional information is needed.

Alan Zoyhofski
Supervisor Name

(585) 477-4309 585 253-0122
Telephone Number: Fax Number:

Odessa Green
Human Resource Representative Name:

(585) 253-5753 585 253-6711
Telephone Number: Fax Number:

Both the completed Employers Statement and this form should be faxed or mailed directly to MetLife in the envelope provided.

MetLife

Telephone Number: 1-800-300-4296 Fax Number: 1-866-690-1264

Metropolitan Life
AND AFFILIATED COMPANIES

Metropolitan Life Insurance Company
Group Life/LTD Section
Oneida County Industrial Park
P.O. Box 3017
Utica, NY 13504-3017

Employer's Statement

Claimant's Name: John C. Magee

Current Job Classification or Title: Program Assurance Manager

I. Educational Background:

Grade Completed: 1-8 ☐ 9-12 ☐

Some College ☒ College Grad ☒

II. Work Experience:

Previous job titles held with present employer: Quality Engineer, Quality Manager, Project Quality Leader, MFG Process Supervisor

Previous job titles prior to employment with present employer: Unknown

III. Formal or informal training: Clarkson University, BS, Mech Engineering

040823013664

Please check appropriate box to indicate current occupation requirements. When more than one exposure or activity is listed per line, cross out that which does not apply.

Exposure to:	0%	1-19% Working Day	20%-60% Working Day	61%-100% Working Day
Dust/gas/fumes		X		
Chemicals/solvents		X		
Temperature extremes	X			
High noise levels		X		
Allergenic agents	X			
Enclosed spaces		X		
Wet conditions	X			
Reduced lighting levels		X		
Electrical sources	X			
Other				

Explanation:

Required Activities:	0%	1-19% Working Day	20%-60% Working Day	61%-100% Working Day
Sitting				X
Standing		X		
Walking		X		
Climb stairs/ladder/scaffold		X		
Balancing (Exposure to falling)	X			
Cramped/unusual positions	X			
Extended reach forward/overhead	X			
Push/pull/twist	X			
Grasp/handle	X			
Bend/stoop/squat		X		
Fine hand dexterity			X	
Highly repetitive motion	X			
Forceful wrist twisting	X			
Operate truck/dolly/small vehicle	X			
Operate heavy equipment	X			
Fine visual auditory attention				X
Precise verbal/written communication				X
Other				

Explanation:

040823.013664

Carrying & Lifting Requirements

Intensity In Pounds:	Frequency: Percentage of Workday			
	Never	Less Than 20%	20%-60%	Greater Than 60%
0-15				X
16-30		X		
31-45		X		
>-45	X			

Explanation (if necessary):

V. Supervisory Functions (if applicable): John is responsible for providing daily Tasking of a Quality Engineer who works the same program John had been working.

VI. Other Significant Factors or Comments:

Prepared By: [signature]

Date: 16 Aug 04

040816035121

OCC

Metropolitan Life Insurance Company

MetLife®

MetLife Disability
PO Box 14590
Lexington, KY 40511-4590

August 12, 2004

John Magee
71 Ontario Street
Honeoye Falls, NY 14472

2nd Request

Re: Kodak Long-Term Disability (LTD) application
Claim No.: 640407128904
Kodak No.: 620820

Dear Mr. Magee:

This is to follow up on our recent letter to you dated July 13, 2004, a copy of which is enclosed.

A review of your file indicates that we have yet to receive the MetLife Statement of Claim package.

Please be sure that we are provided with this information as soon as possible as we are not able to process your LTD application without it. If the information is not received by office within the next 2 weeks, your file will be considered closed.

If you should have any questions, please feel free to contact our office.

Sincerely,

Peter Knoth
Case Management Specialist
Met DisAbility
1-800-300-4296

Enclosure

040816019146

MetLife®

MetLife
P.O. Box 3017
Utica, NY 13504

Met DisAbility
Long-Term Disability Claims
Personal Profile Evaluation Form

KODAK EMPLOYEE NAME: John C. Magee

SOCIAL SECURITY NO.: 088-54-4213

INSURANCE NO.: 620820

Kodak Employee: Please complete this form and submit it with your claim for Kodak Long-Term Disability (LTD) Benefits. Failure to answer any of these questions may delay the processing of your claim for LTD benefits.

1. Please provide us with a brief description of your present condition. Describe any physical complaints or limitations. Chronic Fatigue Syndrome/ Fibromyalgia. Intense fatigue, muscle & joint pain worsening on activity. Sensitivity to light - Problems with reading. Short term memory problems. Massive headaches and other "flu" like symptoms. Fatigue does not go away with rest. Dizziness & vertigo etc.

2. Briefly describe all of your daily activities in a typical day:
Wake up around 10am - Get out of bed by about 11. Come downstairs & have coffee while laying on couch. Shower around 1pm (after pain meds have taken effect). Dress & lay down/ watch TV, read to child etc. Around 2 or 3 do bills/housework/maintenance. Back on couch ~5pm have dinner ~6pm (sometimes @ table, sometimes on couch). Help kids w/ homework. Back to bed.

Do you need any special help to take care of your personal needs and grooming? If so, explain what kind of help you require (washing, bathing, dressing, etc.) why, and how often:
None, though may skip shower if too sore or tired -

What kind of housework do you do (laundry, vacuuming, dusting, mopping, washing dishes, household repairs, lawn care, shoveling snow, etc.)?
When I can, I will do laundry/ household repair/ car repair but am limited by pain/ dizziness etc.

How often do you do this housework (daily, weekly, twice a week)?
~3 times a week

Does anyone help you with housework? yes If yes, explain why and how often:
Wife & 5 kids do most of work

Does anyone help you shop? yes If yes, explain: Wife does majority of shopping

Have there been any changes in your ability to care for your household needs since your condition began? If so, explain: yes - House is falling into dis-repair as I can't keep up. Same with auto. I no longer cook or clean (very often). Can't often concentrate to do bills, submit insurance claims etc.

3. What kind of hobbies, interests, or other activities do you have (fishing, bowling, sewing, swimming, traveling, sports, movies, etc.)?
Watching kids sports

How often do you do these activities (daily, weekly, twice a week)?
on average 1x month

4. Do you participate in any social or community type of activities? Yes X No ___ If yes, list and briefly describe each activity.
Attend church

How long have you been active in these activities? Do you hold any offices in any group?
I have gone to church on & off all my life. I do not hold any office

5. **EXPERIENCE:** Please list all of the jobs you have held:

Occupation	Employment Dates	Usual Duties
Program Assurance Manager	2002 TO 2004	Write of complex plans; facilitating meetings; Dealing w/ Vendors Customer Satisfaction, teaching facilitation mtgs
Quality Manager	1999 TO 2002	
Quality Manager	1996 TO 1999	Commercialization of Products
Quality Engineer	1995 TO 1996	~~Current~~ Quality Assurance for current products

6. Have you ever tried to resume any type of work? Yes X No ___ If yes, give details, including names, dates, compensation paid, duties, etc.
I had gone out STD in the spring of '03 & tried to return to work in the fall, I was not able to keep up w/ job ~~requirements~~ requirements

7. Please provide us with a brief summary of your educational background including any academic, commercial, or vocational training you may have received:
I have a BSME from Clarkson College of Technologies. I have taken many vocational training courses in engineering/ teaching/ quality. I also have a Black Belt in Six Sigma Quality.

EDUCATION: Please circle the highest grade level achieved:

04001091146

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 (16) 16+

DEGREES/CERTIFICATIONS: Please indicate any Degrees/Certifications held:

BSME Black Belt in Six Sigma Quality

VOCATIONAL TRAINING: Please indicate any Vocational Training Courses you have had:

SKILLS: Please describe the skills you have acquired as the result of your education, training, work, experience and hobbies:

I have many skills in the Quality arena including statistics, DOE's etc

MILITARY: If you were in the military, please outline your military responsibilities:

8. Do you expect to return to your last occupation either on a full or part-time time basis? Please explain:

IF symptoms ever relent - I would love to return to work

9. Do you expect to return to some other type of occupation either on a full or part-time time basis? Please explain:

not in my present condition. My passion is my current job & I would return to it.

10. Please provide us with a brief description of any other sources of income you are receiving at this time, including any Social Security entitlements, Workers' Compensation, Railroad Retirement awards, etc., and benefits received from any insurance.

At present, there are no other sources of income, though I have applied for SSI

DATE: 7/26/04 SIGNATURE OF EMPLOYEE:

KODAK LTD REIMBURSEMENT AGREEMENT & FACT SHEET

LTD. Date:

In consideration of the Kodak Long-Term Disability (LTD) Plan payments that will be made to me if my application for LTD is approved, I agree as follows:

(1) Kodak and Metropolitan are authorized to obtain from Social Security Administration any information regarding my claim for Social Security Disability Insurance Benefits ("SSDIB") which Kodak and Metropolitan deem necessary to determine my LTD Plan payments.

(2) If I receive an award of SSDIB or Workers' Compensation Income Replacement Benefits, I will immediately notify Metropolitan. If the award is retroactive, I will, within 30 days of the receipt of the award, reimburse Metropolitan. The amount reimbursed shall be equal to that portion of the LTD Plan payments which would not have been paid if Metropolitan had known the amount of the retroactive award(s) prior to the period covered by the award(s) and, with that knowledge, had reduced the LTD Plan payments in accordance with the LTD plan. Reimbursement checks will be made payable to Metropolitan Life Insurance Company.

(3) If any overpayment of such disability benefits is credited to my account in error, I authorize and direct the Bank to charge my account and to refund such overpayment to Metropolitan.

(4) If I fail to reimburse Metropolitan within 30 days, Metropolitan is authorized to recover an amount equal to the reimbursement owed, plus interest at the maximum rate permitted by law, by appropriate means, including but not limited to deductions from my LTD Plan payments.

(5) If Metropolitan commences an action to enforce this Reimbursement Agreement, Metropolitan shall be entitled to collect from me its costs and expenses of the action, including but not limited to reasonable attorneys' fees.

Important additional facts

1. Medical Exams
   You must report for medical exams when requested to do so by the Kodak Medical Department/Disability Management Organization, or by the Metropolitan Life Insurance Company.

2. Rehabilitative Employment
   While you are disabled, you may also receive earnings from company-approved, rehabilitative, non-Kodak employment intended to help restore you to gainful employment. This employment may be approved for up to one year and may be extended if circumstances warrant. To encourage rehabilitative employment, an amount equal to only 50% of your rehabilitative earnings will be deducted from your Kodak LTD benefit.

3. If you Recover from Disability
   If the Metropolitan Life Insurance Company determines that you have recovered from disability, LTD benefits will be discontinued. Kodak is not obligated to offer you employment after you recover, but you are welcome to complete an employment application.

I acknowledge that I have read the above information and have received a copy of this Reimbursement Agreement/Fact Sheet. I have received a copy of the Long-Term Disability summary plan description.

7/26/04 — *Date*

Employee Signature

Date Prepared:

040816-019146

STATEMENT OF CLAIM FOR LONG TERM DISABILITY BENEFITS

MetLife
MetLife Disability
P.O. Box14590
Lexington KY 40511-4590
Fax: 1-866-690-1264
Fax this Form to expedite your claim - retain original for your records.

TO BE COMPLETED BY THE EMPLOYEE (Please answer all questions)

Your name (Print) John Magee Telephone (585) 624-9306

Residence address 71 Outwest St City Honeoye Falls State NY Zip Code 14472

If you are not at home, where are you presently located ____ City ____ State ____ Zip Code ____

☑ Male ☐ Female ☐ Single ☐ Married SS# 088-54-4213 Date of birth 12/7/59 Spouse's date of birth 8/31/60

Birth date of all dependent children 10/27/87 2/4/90 12/8/91 1/7/95 8/1/2001

(Dependent children are all unmarried children (1) under age 18, (2) under age 19 if in elementary or secondary school and (3) handicapped children regardless of age if the disability began before age 22.)

What is your occupation? Provide a brief description of the job activities, environment, unusual condition, etc.
Program Assurance Manager - Ensure govt programs meet/~~exceed~~ exceed specifications
Ensure compliance by all vendors/sub-contractors. Report program risks etc. Travel required

Date you were first disabled by this sickness or injury 12/5/03 2003

Are you now able to return to your job with or without reasonable accomodation? ☐ Yes ☒ No If yes, date you could return ____

Are you now able to perform any Gainful Work (paid employment for which you are qualified or could become reasonably qualified by education, training or experience), with or without reasonable accommodation? ☐ Yes ☒ No If yes, date you could return to work ____

Have you performed any type of work (either for this employer, another employer or through self employment) since your disability began? ☐ Yes ☒ No

If yes, provide name and address of employer, type of work, when employment began and number of hours worked per week.

Was an accident involved? ☐ Yes ☒ No If yes, please answer the following:

(a) When did the accident happen? Date ____ 20 ____ at ____ (Hour) (a.m. p.m.)

(b) Where did the accident happen? City ____ State ____

(c) Were you at work when the accident happened? ☐ Yes ☐ No
Have you or do you intend to file a claim for Worker's Compensation benefits? ☐ Yes ☐ No

(d) Was sickness or injury result of an auto accident? ☐ Yes ☐ No Have you or do you intend to file a claim for No Fault Auto benefits? ☐ Yes ☐ No

(e) Give a brief description of the accident ____

Name all physicians who have treated you since the beginning of this disability

Name of Physician	Address of Physician	Phone Number	Dates of Treatment From	To
Dr. David Bell	775 S. Main St Lyndonville 14098	(585) 765 2060	~1999	present
Dr. Alice Taviot	100 Linden Oaks Roch NY 14625	(585) 586 1600	2004	present
Carolyn Cascone	253 Alexander St Roch NY 14607	(585) 423-9460	2002	present

If you were hospitalized as a bed patient, please answer the following:

(a) Name and address of hospital ____

(b) Date admitted ____ 20 ____ at ____ (Hour) (a.m. p.m.) (c) Date discharged ____ 20 ____ at ____ (Hour) (a.m. p.m.)

Describe any other income you are receiving or are eligible to receive as a result of your disability: *(Examples: Social Security, Worker's Compensation, State Disability, Pensions)*

Source	Amount of Income	Date Income Began	Date Income Ended
SSI	unknown	—	—

Important—Please attach a copy of any Social Security Award Certificate, Social Security Disability Denial Notice or other correspondence explaining a decision received from the Social Security Administration. If you have not yet applied for Social Security, please submit a copy of the decision when received.

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I represent that I have provided complete answers to the above questions and that said answers are true and correct to the best of my knowledge.

Date 8/9/04 Claimant's Signature [signature]

00202030000000000034.J$

JE5147.SCRE(10/02)

040816019146

MetLife

Financial Index for Claim #_____

METROPOLITAN LIFE INSURANCE
CONSENT FOR RELEASE OF SOCIAL SECURITY INFORMATION

TO: Social Security Administration Federal Bldg Rochester, NY 14614
(ADDRESS OF OFFICE WHERE YOU APPLIED)

Upon Presentation of the original or a photocopy of this signed authorization,

I, John C. Magee 12/7/59 088-54-4213
(NAME OF CLAIMANT) (DATE OF BIRTH) (SOCIAL SECURITY #)

hereby, authorize the Social Security Administration to send a copy of the **award or disallowance notice** and release the information or records requested below to Metropolitan Life Insurance Company, its employees or agents. Please mail the information to:

Metropolitan Life Insurance Company
Disability Claims Section
P.O. Box 14590
Lexington, KY 45011-4590
Fax: 1-866-690-1264

I want this information released because:

This information is required by MetLife to calculate my disability benefits.
(There may be a charge for this information.)

Please release the following information:

- Type of benefits being paid to claimant _____
- Entitlement date and initial monthly benefit. Please include any credit for additional earnings and effective date.
- Entitlement date and initial monthly benefit for all dependents; include increases, credit for additional earnings and termination dates.
- If claimant is dually entitled, the portion paid under their own number.
- Amount of benefits received or will be available to spouse on claimant's work record at age 62 or older. (Please have spouse sign below)
- Complete payment history: dates and reasons for increases, decreases, or offsets.
- If the claim has not been approved, it is:
  - Pending---Level_____ Denied---Date/Level_____
  - Appeal filed---Date/Level_____
- Other (specify)_____
- (Please have spouse sign below)

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

SIGNATURE: [signature] DATE: 7/26/04

SPOUSE'S SIGNATURE: _____
(IF SPOUSE'S RECORDS ARE BEING REQUESTED)

(Show signatures, names and addresses of two people if signed by mark)

0050101000000000000J2

JY5585.SCRE(08/03)

040816019146

Form W-4 (2004)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2004 expires February 16, 2005. See Pub. 505, Tax Withholding and Estimated Tax.

Note: *You cannot claim exemption from withholding if: (a) your income exceeds $800 and includes more than $250 of unearned income (e.g., interest and dividends) and (b) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. **However, you may claim fewer (or zero) allowances.**

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line E below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2004. See Pub. 919, especially if your earnings exceed $125,000 (Single) or $175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A 1
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,000 or less.	B 1
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D 3
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $1,500 of **child or dependent care expenses** for which you plan to claim a credit (Note: *Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.*)	F
G	**Child Tax Credit** (including additional child tax credit): • If your total income will be less than $52,000 ($77,000 if married), enter "2" for each eligible child. • If your total income will be between $52,000 and $84,000 ($77,000 and $119,000 if married), enter "1" for each eligible child plus "1" additional if you have four or more eligible children.	G 0
H	Add lines A through G and enter total here. Note: *This may be different from the number of exemptions you claim on your tax return.* ▶	H 14

For accuracy, complete all worksheets that apply.
- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $35,000 ($25,000 if married) see the **Two-Earner/Two-Job Worksheet** on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

---------- Cut here and give Form W-4 to your employer. Keep the top part for your records. ----------

Form W-4 — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ Your employer must send a copy of this form to the IRS if: (a) you claim more than 10 allowances or (b) you claim "Exempt" and your wages are normally more than $200 per week.

OMB No. 1545-0010

2004

1 Type or print your first name and middle initial: John C — Last name: Magee — 2 Your social security number: 048 54 4213

Home address (number and street or rural route): 71 Ontario St

3 ☐ Single ☒ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

City or town, state, and ZIP code: Niagara Falls, NY 14472

4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ▶ ☐

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2) — 5: 14

6 Additional amount, if any, you want withheld from each paycheck — 6: $

7 I claim exemption from withholding for 2004, and I certify that I meet both of the following conditions for exemption:
- Last year I had a right to a refund of all Federal income tax withheld because I had no tax liability and
- This year I expect a refund of all Federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt" here ▶ 7

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.

Employee's signature (Form is not valid unless you sign it) ▶ [signature] Date ▶ 7/26/04

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | 9 Office code (optional) | 10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2004)

ML0546

040816019146

METROPOLITAN LIFE INSURANCE COMPANY
AUTHORIZATION FORM FOR
ELECTRONIC FUNDS TRANSFER OF DISABILITY PAYMENTS

MetLife

INSTRUCTIONS

Submit the completed, signed original of this form to:

METROPOLITAN LIFE INSURANCE CO.
P.O. BOX 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

EMPLOYEE: Eastman Kodak

SOC SEC #: 088 - 54 - 4213

GROUP #: _____

GROUP NAME: _____

I authorize Metropolitan Life Insurance Company to send my disability payments to the Bank designated below for electronic deposit in my Account. I understand that I may terminate this arrangement at any time by writing to the Metropolitan address above.

If any overpayment of such disability benefits is credited to my Account in error, I authorize and direct the Bank to charge my Account and to refund such overpayment to Metropolitan.

PLEASE COMPLETE THE FOLLOWING:

Type of Account (check one): Checking X Savings ____

Account Number: 9833550644

Name of Bank (Print): M & T Bank

Address of Bank: N. Main St (Street)

Honeoye Falls, NY 14472 (City, State, Zip)

Bank Telephone (800) 724-2440

Bank Routing Number: 022000046

Obtain this number from your bank

or

Attach a Voided check

7/26/04
DATE

SIGNATURE

JY5584.SCRE(06/01)

MetLife
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

This authorization has been drafted to permit disclosure of health information consistent with the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for completing the form:
1. Complete all applicable areas of the form.
2. If you are the Claimant's Personal Representative, include a copy of the legal document(s) authorizing you to act on behalf of the Claimant.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim - retain the original for your records.

Your refusal to complete and sign this form may effect your eligibility for benefits under your employer's long-term disability plan.

John C. Magee
Name of Claimant (Please Print)

088-54-4213
Social Security Number

Claim Number: 640407128904

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me:

1. **I permit** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), in its capacity as claims administrator of the long-term disability plan available through my employer, employees of my employer who administer such plan, and any investigative agencies, attorneys, and independent claim administrators acting on behalf of MetLife or my employer, any and all information about my health, medical care, employment, and disability claim.

2. **I permit** MetLife to disclose to employees of my employer administering the benefit plans maintained by my employer any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permission to disclose medical information, records, test results, and data on my medical care or surgery, mental illness or condition (excluding psychotherapy treatment records and notes) and alcohol or drug abuse, including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. I understand that information concerning mental illness, HIV, AIDS, HIV related illnesses, and sexually transmitted diseases or other serious communicable illnesses may be controlled by various federal and/or state laws and regulations and I consent to disclosure of such information, but only in accordance with such laws and regulations as they apply to me. Information that may have been subject to privacy rules of HIPAA, once disclosed, may be subject to redisclosure by the recipient and may no longer be covered by those rules.

I understand that I may revoke this authorization at any time by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40511-4590, except to the extent that action has been taken in reliance on it. Unless revoked, this authorization will be valid for 24 months from the date it is signed or the duration of my claim for benefits, whichever period is shorter.

I further understand that a photocopy of this authorization is as valid as the original and I have a right to receive a copy upon request.

Signature of Claimant or Claimant's Personal Representative

7/26/04
Date

For Personal Representative of the Claimant (if applicable):

Print Name and Representative Capacity: _____

Attach a copy of the legal document(s) authorizing you to act on behalf of the Claimant.